Welcome to One Community Health!

New Patient Registration

ONE COMMUNITY HEALTH
CARING FOR ALL, CARING WITH HEART
CUIDANDO A TODOS, CUIDANDO CON EL CORAZÓN

1. About you

Last Name	First Name	Gender	Preferred Language
Mailing Address	City, State, Zip	Date of Birth (MM/DD/YYYY)	Social Security Number
Physical Address (if different)	City, State, Zip	Mobile Phone #	Home Phone #
Email address		Best number to use: ❑ Mobile Phone # ❑ Home Phone #	

2. Responsible party / Guarantor (if different from above)

Last Name	First Name	Date of Birth (MM/DD/YYYY)	Preferred Language
Mailing Address	City, State, Zip	Social Security Number	Mobile Phone #
Relationship to Patient		Home Phone #	Email address

3. Insurance Information

Primary Insurance			Policy #	Secondary Insurance			Policy #
Subscriber Name / Name of Insured			Group #	Subscriber Name / Name of Insured			Group #
Subscriber Date of Birth	Policy Effective Date	Expiration Date		Subscriber Date of Birth	Policy Effective Date	Expiration Date	

Sharing Your Visit with Your Primary Care Doctor

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One Community Health (OCH) will only release Protected Health Information (PHI) as permitted by patient confidentiality laws. OCH reserves the right to use or disclose patient's PHI without patient's consent to the extent allowed by applicable law, including but not limited to uses or disclosures identified in OCH's Notice of Privacy Practices.

Patient

Last Name	First Name	Date of Birth (MM/DD/YYYY)

Your Primary Care Doctor

Name	Phone

Mailing Address	City, State, Zip

Protected Information to Share

Certain information cannot be released without specific authorization as required by state or federal law. By checking the specific boxes below, you authorize the disclosure of the following protected information with your doctor:

- ❑ Mental health diagnoses, prognosis, and treatment
- ❑ Substance use diagnoses, prognosis, and treatment
- ❑ Pregnancy information
- ❑ HIV / AIDS Virus
- ❑ Sexually Transmitted Diseases

Authorization

- I understand that this authorization is valid as long as I am a patient of Hood River Valley High School Health Center, or I revoke my authorization.
- I understand that I may revoke this authorization in writing at any time but that revocation of this authorization will not apply to information already released.
- This form is not valid unless signed and dated.

Signature of Patient / Representative	Date

Printed Name	Relationship of Personal Representative

Consent to Disclose Health Information Verbally

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Patient

Last Name	First Name	Date of Birth (MM/DD/YYYY)

Authorized Phone Number(s)

I hereby authorize OCH staff to leave detailed voicemail messages at the following phone number(s):

Phone Number(s)

Authorized Person(s)

I hereby authorize OCH staff to discuss my PHI with the following person(s):

Name	Relationship to Patient	Phone

Certain information cannot be released without specific authorization as required by state or federal law. By checking the specific boxes below, you authorize the disclosure of the following protected information with the listed family or friends above:

- ❑ Mental health diagnoses, prognosis, and treatment
- ❑ Substance use diagnoses, prognosis, and treatment
- ❑ Pregnancy information
- ❑ HIV / AIDS Virus
- ❑ Sexually Transmitted Diseases

Authorization

- I understand that this authorization is valid as long as I am a patient of OCH, or revoke my authorization.
- I understand that I may revoke this authorization in writing any time, but that the revocation of this authorization will not apply to information already released.
- This authorization allows for verbal communication (both in person and on the telephone) between OCH and the designated person(s) on this form. It does not allow for copies of medical records to be released.
- This form is not valid unless signed and dated.

Signature of Patient / Representative

Date

Printed Name

Relationship of Personal Representative

Application for discount program

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For your assistance, we have a discount program. In order for us to determine if you qualify, please provide us with the following information, in addition to proof of income. Common proofs of income include:

- Last year's taxes
- Wages and Salary
- Unemployment
- Self-employment records
- Social Security / SSI
- Worker's Compensation
- Public Assistance / Food stamps
- Disability
- Pension funds
- VA Benefits
- Grants/Scholarship

❑ Provide Household Information

How many people are supported by this income? Use the number of persons *who live in the same household and who share income, food and rent*. That number may include you, your spouse, and/or any dependents.

Name	Date of Birth
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

FOR OFFICE USE ONLY

All fields must be completed. Attach all proof(s) of income to this application. Run two tapes on calculator and attach to form.

Verified annual income	
# in Household	
Discount Level	
Proof of income	
Approved by	
Staff Name	
Date entered	
Chart #	
Account #	

Billing Department Review by Date

❑ Self-Declared Homeless / No income (applies for ONE VISIT ONLY)

How are you receiving food and shelter?

If declared homeless, please check all that apply to your current living situation:

- ❑ In parks / on streets / under bridge
- ❑ Living in vehicle
- ❑ Hotel / motel
- ❑ Staying with others, no rent
- ❑ Camping / traveling with no income
- ❑ Recently incarcerated

Authorization

To the best of my knowledge, the information given is true and correct. I give One Community Health (OCH) permission to verify information about my financial status. I understand this information must be provided within 30 days of the date of the visit to qualify for the sliding fee discount, and that if I do not provide proof of income, I will responsible for the full fee for the visit.

Signature of Patient / Guarantor Date

Help One Community Health help you!

Income Questionnaire

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We are a community health center and are required to collect income information from all patients. This information helps us to provide services to you and receive grant funding to assist you. Please complete this form, all answers are confidential and are not shared with any other organization or program.

Responsible Party / Guarantor

Last Name	First Name	Date

1. Number of people living in your household (please circle):

1 2 3 4 5 6 7 8 Other:_____

2. Estimated yearly household income (check the most accurate box below):

❑ $0-5,000	❑ $25,001-30,000	❑ $50,001-55,000	❑ $75,001-80,000	❑ $100,001-110,000
❑ $5,001-10,000	❑ $30,001-35,000	❑ $55,001-60,000	❑ $80,001-85,000	❑ $110,001-120,000
❑ $10,001-15,000	❑ $35,001-40,000	❑ $60,001-65,000	❑ $85,001-90,000	❑ $120,001-130,000
❑ $15,001-20,000	❑ $40,001-45,000	❑ $65,001-70,000	❑ $90,001-95,000	❑ $130,001-140,000
❑ $20,001-25,000	❑ $45,001-50,000	❑ $70,001-75,000	❑ $95,001-100,000	❑ Other _____

❑ Declined to disclose

Authorized Caregiver(s) for Minors

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Parent / Legal Guardian

Last Name	First Name	Relationship to Minors

Child

Name

Authorized Person(s)

Name	Relationship to Child

Authorization

- ■ I hereby give my authorization and consent for the below named authorized person(s) to consent to the medical / dental care and treatment of my child(ren). I hereby authorize and grant that the below named person(s) has / have permission to sign for any medical / dental procedures or treatments deemed necessary for the well-being of my child(ren).
- ■ I am, by this document, representing that I have the authority to consent for all medical / dental care and treatment of said child(ren).

Signature of Parent / Legal Guardian Date